Michigan Department of Community Health **EMS and Trauma Systems Section** 201 Townsend Street Lansing, Michigan 48913	**MDCH USE ONLY** Date Received by Regional Coordinator: _____ Date Amendments Requested: _____ Amendments Received: _____ Date to MDCH: _____ Date Interim Review Notice to Sponsor: _____ Recommend Approval ☐ Yes ☐ No Regional Coordinator Signature _____

APPROVED EMS EDUCATION PROGRAM SPONSOR
APPLICATION FOR A SATELLITE COURSE AT NEW LOCATION

This original notification must be received by the Department <u>at least 60 days prior</u> to the start of the course. Receipt less than 60 days prior will result in delay of start date. Failure to complete and submit this form as prescribed may result in the education program sponsor approval revocation. If changes are made to a previously approved course, this form must be submitted as soon as changes are known.

1.

Education Program Sponsor			
Address			
City	State	Zip	County
Sponsor Contact Person Name:	Title		Telephone Number
Program Sponsor Approval #:		Approval Valid Through:	

2.

Level of course to be offered:

_____ MFR	_____ EMT Matriculation
_____ Basic EMT	_____ Basic EMT Refresher
_____ EMT-Specialist	_____ EMT-Specialist Refresher
_____ Paramedic	_____ Paramedic Refresher
_____ Instructor/Coordinator	_____ Instructor/Coordinator Refresher

3.

Dates of Course:
Start _____ Ending _____

Meeting Days: S M T W Th F S Class Hours: _____

4.

Specific Course Location_____ (Building, Room Number)_____

Address_____

_____

5. **Satellite Course at New Location:**

a. IDENTIFY ANY AND ALL CHANGES RELATED TO THIS SATELLITE LOCATION THAT ARE DIFFERENT THAN THE ORIGINAL CRITERIA FROM THE INITIAL PROGRAM SPONSOR APPLICATION:
(e.g., change of course coordinator, physician director, additional faculty, additional clinical contracts, etc.)

b. Attach required documentation:

1. Dates satellite location to be active
2. Sponsor representative at satellite location
3. Satellite course coordinator (I/C) and credentials if different than primary site course coordinator
4. Satellite location physician director. Include credentials if different the primary site physician director
5. Provide action plan that documents how sponsor will provide oversight to satellite location to ensure State requirements are met
6. Provide written agreement between sponsor and satellite site identifying responsibilities of each.
7. Provide written plan to promote communication and evaluate progress among sponsor representative, satellite location representative, and satellite course coordinator.
8. Provide documentation to ensure curricula, exams, evaluation tools, policies and procedures used must be consistent among all sponsor locations.
9. Provide equipment inventory and A/V resource list. If program is running concurrently with primary site program, must have enough equipment for both sites.
10. Ensure students have written contact information for contacting sponsor representative during course and after course completion
11. Provide documentation that sponsor has approved all I/C's, subject matter experts, and qualified instructors. Attach documentation if different from primary site.
12. Identify clinical sites to be used by satellite program and provide copies of contracts if different from sponsor's primary clinical sites
13. Document provisions for satellite program students to have access to resources equivalent to those at the primary site, including library, assessment, tutoring and financial aid.
14. Identify location where program records will be kept during course and where they will be kept after course completion
15. Provide documentation that Sponsor is providing financial support for the satellite program
16. Document the satellite program has a representative on the sponsor's advisory committee
17. Adhere to all other primary site responsibilities

b. **ATTACH COURSE SCHEDULE** (UTILIZE THE ATTACHED FORMAT).

6. **REQUIRED SIGNATURES**

Course Coordinator:
I affirm my commitment to serve as Course Coordinator and to comply with all MDCH requirements for education program Course Coordinators, as described in the program approval packet.

Program Course Coordinator Name	Title	Telephone Number
		( )
Original Signature - Program Course Coordinator		Date

Program Sponsor Representative:
I affirm that all information submitted with this form is true and that the Program Sponsor continues to comply with all requirements upon which the program sponsor approval was based. The Sponsor assumes full responsibility for this course and will provide necessary oversight of the course.

Printed Name of Authorized Program Sponsor's Representative	Title	Telephone Number
		( )
Original Signature – Authorized Program Sponsor's Representative		Date

Physician Director :
I affirm that all information submitted with this form is true and that the Program continues to comply with all requirements upon which the program sponsor approval was based. I assure responsibility for medical direction of this course and will provide necessary oversight of the course.

Printed Name of Physician Director	Title	Telephone Number
		( )
Original Signature – Physician Director (Please indicate M.D. or D.O.)		Date

COURSE SCHEDULE

Program Sponsor: _____ **Course Level:** _____ **# Clinical Hours:** _____

Course Coordinator: _____ **Course Location:** _____ **Hospital:** _____

Pre-Hospital: _____

Attach course schedule(s) to application. Schedule must include topics and hours required in MDCH Education Program Requirements.

Lesson Number	Date & Time	Didactic Hours	Practical Hours	Topic	Instructor(s)